MARYLAND HEALTH CARE COMMISSION

Issue & Policy Brief
Informed Consumers...Accountable Health Care

Hospice Services

The Maryland Health Care Commission (MHCC) is an independent commission, members of which are appointed by the Governor with the advice and consent of the Maryland Senate. The responsibilities of the Commission include, among others, the implementation of the Certificate of Need (CON) program for certain health care facilities and services, and the adoption of the State Health Plan (SHP) for facilities and services regulated by the CON program. The Commission coordinates the performance of its regulatory responsibilities and duties with the Department of Health and Mental Hygiene, the Health Services Cost Review Commission, and other administrative agencies in the State.

Definition of Hospice Services

The National Hospice and Palliative Care Organization (NHPCO) defines hospice as a model for quality, compassionate care at the end of life. Hospice care emphasizes pain and symptom management, as well as psychosocial/spiritual support. Care provided by hospice involves a team of professionals and volunteers and is tailored to the needs and wishes of patients and their loved ones. Hospice care is generally home-based, but may also be provided under specific conditions in an inpatient setting.

Maryland hospice care programs are licensed as either general or limited programs. *General* hospice care programs provide skilled medical, nursing, palliative, psychological, social, and spiritual support to patients. General hospice programs may provide care in a home-based setting or in a variety of inpatient locations. *Limited* hospice programs provide non-skilled palliative and supportive services in home-based settings only.

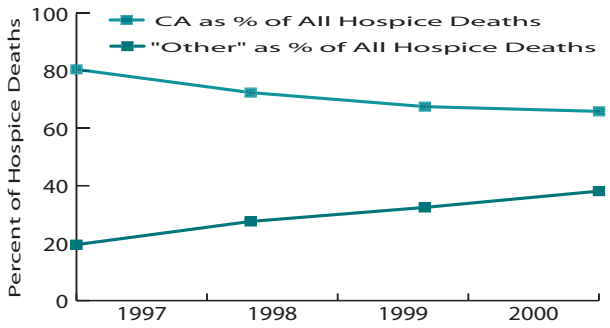
Supply and Use of Hospice Services

In 2001, there were a total of 32 hospices statewide. Twenty-eight hospices had a general license and four had a limited license. Seven Maryland hospices had inpatient programs. Five inpatient programs are located in free-standing facilities, one is in an acute general hospital, and one is located in a nursing home. Each Maryland jurisdiction is served by at least one hospice. Hospice programs served almost 11,000 Maryanders in 2000.

Hospice use by patients with non-cancer life-limiting chronic diagnoses is increasing relative to use by cancer patients.

Hospice Utilization Trends. Historically, cancer (CA) patients have accounted for the majority of hospice utilization. Although cancer patients are still the primary users of hospice care, recent trends indicate that hospice use by patients with non-cancer, life-limiting, chronic diagnoses is increasing. Conditions or diseases other than cancer, as a percent of all hospice deaths in Maryland, increased from 19 to 38 percent between 1997 and 2000.These trends mirror recent national utilization patterns.

Figure 1
Trends in Hospice Deaths by Diagnosis: Maryland, 1997 - 2000

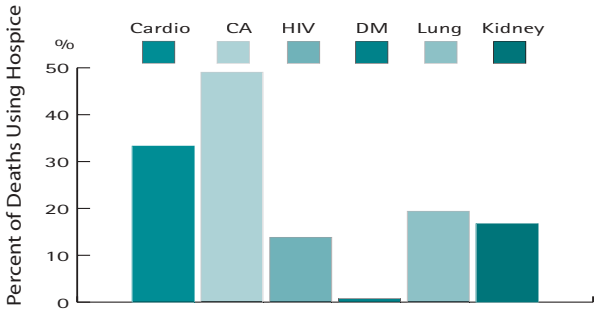


Source: Hospice Network of Maryland, 2000 Survey.

Analysis of hospice use by individuals whose specific cause of death is considered appropriate for hospice care, shows those diseases where hospice penetration is greatest. As shown in Figure 2, cancer and major cardiovascular diseases show the greatest hospice use, while diabetes mellitus (DM) shows the lowest. Patients

with diseases involving respiratory, kidney, and HIV conditions at the time of death show hospice use between 14 and 20 percent.

Figure 2
Hospice Utilization by Major Disease Category: Maryland, 2000 *

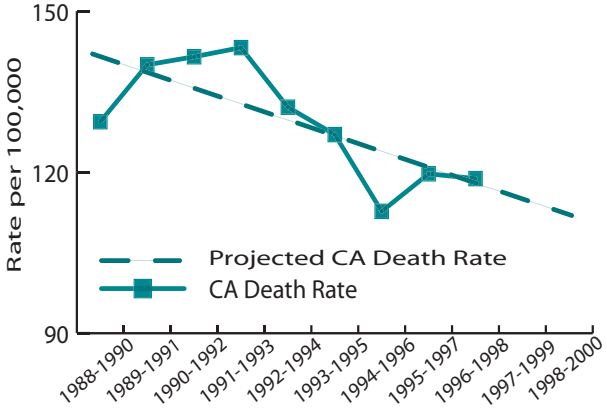


* Calculated by dividing hospice deaths in each disease category by total deaths in each disease category.

Source: Hospice Network of Maryland, 2000 Survey; DHMH Vital Statistics Administration.

An additional factor which may influence declining utilization by cancer patients is that Maryland cancer rates have been gradually declining since 1988 (see Figure 3). Actual three-year age adjusted cancer death rates after 1998 are not available because the change from ICD-9 to ICD-10 diagnostic codes in 1999 rendered some cancer diagnoses incompatible for comparison. However, linear projections based on data through 1998 show a continued downward trend of cancer rates to 2000.

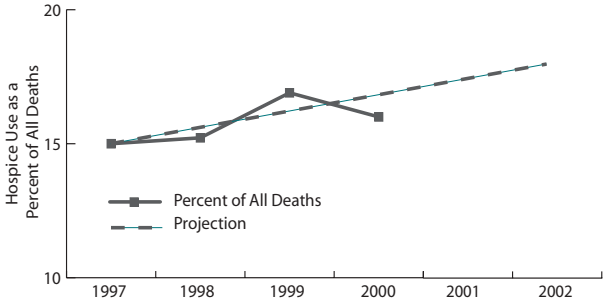
Figure 3
Trends in Three-Year Age Adjusted Cancer Death Rates: Maryland, 1988 - Projected 2000



Source: DHMH, Vital Statistics Administration.

Hospice deaths as a percent of all deaths can be used as an estimate of the extent to which hospice serves as a resource for end of life care. Using this barometer, hospice use increased slightly between 1997 and 2000 (see Figure 4). The linear projection shown by the dotted line indicates that hospice use as a percent of all deaths will continue to increase slowly over the next several years. Growing acceptance of hospice as an option for end of life care may contribute to this trend.

Figure 4
Trends in Hospice Deaths as a Percent of All Deaths: Maryland, 1997 - 2002



Source: Hospice Network of Maryland 2000 Survey; DHMH, Vital Statistics Administration.

How Maryland Compares with the U.S.

Hospice in Maryland differs from the national experience as shown in Table 1.

Table 1
Comparison of Selected Hospice Characteristics: Maryland and U.S. 2000

	Maryland	U.S.
Agency Type		
Free Standing	56%	43%
Hospital-Based	19%	33%
Home Health-Based	19%	9%
Legal Status		
Non-Profit	91%	73%
For Profit	9%	26%
Accredited	78%	62%
Race/Ethnicity		
White/Caucasian	75%	82%
Black/African American	16%	8%
Gender		
Male	44%	45%
Female	56%	55%
Diagnosis on Admission		
Cancer	63%	57%
Other	37%	43%
Medicare Payer	71%	82%
Average Length of Stay	40	48
Median Length of Stay	21	25
Percent Home Care	93%	96%

Source: Hospice Network of Maryland; National Hopice and Palliative Care Organization

Planning for Hospice Services in Maryland

State Health Plan. The Commission plans for hospice services under the State Health Plan for Long Term Care Services (SHP) at COMAR 10.24.08. This chapter establishes the methodology used to project need for hospice services. Projections are utilization-based, and take into account average cancer death rates and population growth estimates by age and jurisdiction.

The SHP contains standards used by the Commission to review proposed new hospice programs. The CON process provides a tool for examining quality issues before the provider begins operation of a new hospice. Need for hospice services is projected by jurisdiction and hospices may not provide services to individuals outside their approved service area.

Projections for 2002 indicate that available hospice services in Maryland are sufficient to meet expected need. Projections for 2005 are currently being developed by the Commission. As part of this update, the Commission will review in detail the assumptions used in the methodology.

Policy Issues

Financing, Reimbursement, and Personnel. Medicare is the principal payer for hospice services in Maryland and the United States, covering 71 percent of all Maryland hospice patients in 2000. Congress increased Medicare hospice reimbursement rates in 1986, 1989, and 2001, and have adjusted the hospice payment annually, based on a hospital market basket index. However, because this adjustment is subject to federal deficit reduction legislation, the index rate has dropped for each of the last several years.

Dramatic improvements in palliative care technology and treatments have reduced lengths of stay in hospice care. The effect of these changes has been higher costs for providing hospice care. Technological advances have resulted in increased use of diagnostic testing and work up as well as increased pharmaceutical costs associated with palliative care. Many intense and complex palliative treatments have become easier to provide in a home setting which has driven up outpatient costs.

Decreasing lengths of stay have also caused increased costs to hospices. Because patients are seeking hospice care later in their terminal illness and spending less time in hospice care, hospices have a shorter period over which to balance the high costs at the beginning and end of care.

Higher costs and less money impacts the ability of hospices to attract and retain nurses. This puts them at a particular disadvantage in an environment where shortages of nursing staff are endemic. To balance these shortages, hospices have had to concentrate more effort on fundraising, which places additional burdens on hospices as well as the communities that support them.

Volunteers. Since its inception in the 1970s, hospice has depended heavily on volunteer staffing. Over time, the ratio of professional to volunteer staff has increased partly because the increase in technology related to hospice care requires a higher level of staff skill. Hospice conditions of participation in the Medicare program require that at least five percent of costs be attributed to volunteer hours. While volunteer hours can provide significant help to hospices faced with increasing costs and decreasing reimbursement, hospices must also compete with other organizations for a limited supply of available volunteers. Growth in the number of hospice providers in a given jurisdiction also increases the competition for volunteers and can, thus, have a strong impact on hospice operations.

Pediatric Hospice Care. Maryland hospices treated 58 terminally ill children under the age of 18 in 2000, only 0.7 percent of children under 18 who died in 2000. Although not all of these children died from causes appropriate for hospice care, many of these children and particularly their families would have benefited from hospice care. The emotional issues surrounding the death of a child are overwhelming, not only for the families but also for the medical professionals who care for them. Parents and physicians are reluctant to accept the impending death of a child. This can lead them to deny the prognosis or to continue seeking a cure until it is too late for them to garner the full benefits afforded by hospice care.

While pediatric hospice may be the preference for some families, not all hospice programs may be able to care for pediatric patients. It may take several years to plan and implement a pediatric hospice program, and once established, it is difficult to find and retain staff that are able to work with terminally ill children. Hospice care for pediatric patients, particularly for young children, may require a different skill set than for adults.

Typically, the decision to use hospice care precludes the concurrent pursuit of curative treatments.

While this is appropriate for adults, it may not be the best practice for children. The intensity of emotional, psychological, and medical needs of children with life-limiting illnesses are best met in the hospice milieu; however, families cannot access these services without forgoing further life saving measures for their children.

Utilization by Minorities. Maryland has a higher rate of minority participation in hospice than the U.S. overall (16 percent and 8 percent, respectively). However, participation by minorities varies by region across Maryland. In Prince George's County, where 74 percent of the population is non-white, only 53 percent of hospice patients are non-white. Similarly, Baltimore City's non-white population represents 69 percent of the total, but only 39 percent of hospice patients are non-white. In Montgomery County and the Eastern Shore, the ratio of the non-white population to non-white hospice patients indicates that non-whites have higher utilization in hospice than whites. Despite these variations, hospices generally experience less minority participation than non-minorities. Cultural differences in the way ethnic minorities view death may contribute to this variation.

Predicting Hospice Need in Maryland. The Medicare six-month rule is a barrier to access for many Medicare recipients with non-cancer diagnoses. This rule requires that individuals have a prognosis of 6 months or less before being eligible for the Medicare hospice benefit. With increases in life expectancy and the aging of the baby boom population, the number of individuals living with life limiting chronic illness will increase. Research has shown that individuals with life-limiting chronic illness who maintain constant contact with a medical care manager experience a more stable decline before death and a better death experience. The medical and insurance industries, however, are based on a model of care that is deeply rooted in the acute hospital environment, which may preclude this type of care management.

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High expectations of the baby boom generation have prompted many societal changes over the years, and policy makers may be short sighted if they do not anticipate that boomers will demand more flexible options as they cope with chronic illness and death in the decades to come. Although the future of the six-month rule is unknown, it is likely that societal pressures will, at the very least, force its modification to allow more individuals access to palliative care.

How a change in this rule will impact the need for hospice services is not known. Although it may increase the money spent for hospice services, it may also decrease the money spent for acute hospital-based life sustaining measures. Hospice is only one option for the terminally ill. Philosophical and spiritual issues also influence the decision for hospice care. However, given the continual growth of hospice since its beginning three decades ago, it is likely that acceptance of this option will only increase. Continued monitoring of hospice utilization will help the Commission and other policy makers to respond as demand changes. ■

Sources of data and information

1. Hospice Network of Maryland 1997, 1998, 1999, 2000 Annual Surveys.

2. The Costs of Hospice Care: An Actuarial Evaluation of the Medicare Hospice Benefit; Cheung, L., Fitch, K., Pyenson, B.; Milliman USA, Inc.; August, 2001

3. Maryland Department of Health and Mental Hygiene, Division of Health Statistics

4. National Hospice and Palliative Care Organization web site; www.nhcpo.org

5. Hogan C, Lunney C, Gable J, Lynn J (July/August 2001) "Medicare Beneficiaries" Costs of Care in the Last Year of Life, "*Health Affairs*, vol. 20 no. 4, pp. 188-195.

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